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Managed Care Debates: Texas, Congress, and the Courts

Texas has been a leader in enacting legislation to regulate managed health care and in defining enrollees’ recourse against decisions made by or on behalf of health-maintenance organizations (HMOs). Congress has considered proposals similar to Texas’ law, and many other states have adopted or considered such proposals. But health-care providers, HMOs, consumers, and lawyers still have concerns about these laws, and federal and state courts are hearing challenges to several aspects.

Managed care, or health-care coverage that controls or influences a patient’s use of services and providers, has become the dominant health-care delivery system, covering two-thirds of the U.S. population, according to Managed Care On-Line, an Internet managed-care resource company. HMOs, which provide managed care on a *prepaid* basis, cover about 3.9 million Texans for general health-care services, or almost 20 percent of the state’s population, according to the Texas Department of Insurance (TDI).

Managed-care plans steadily have replaced indemnity health plans, which pay providers for each service rendered, or on a *fee-for-service* basis. Managed-care plans have become increasingly attractive to employers since the late 1980s because of rising health-care costs and the limitations of indemnity insurance plans in ensuring the provision of cost-effective health-care services.

Texas’ system of managed health care may undergo further scrutiny by the 77th Legislature because of issues raised by patients, doctors, and HMOs.

This report briefly describes the history, debate, court challenges, and current federal and state legislative proposals surrounding three major components of Texas’ managed-care law: patient protections, the “right to sue,” and provisions allowing doctors to join together to negotiate contracts with HMOs and other managed-care providers.

Patient protections

“Patient protections” generally refer to consumer- and doctor-supported requirements imposed by government on HMOs or other managed-care organizations. These provisions often relate to physician contracting and payment, communications with enrollees, benefit coverage, and complaints and appeals. Congress has debated patient-protection provisions for the past few sessions, and most states have implemented or are considering them.

The Texas Legislature first enacted patient-protection legislation in 1995 (HB 2766 by Smithee). Gov. George W. Bush vetoed the bill, saying it would have imposed many new regulations at a significant cost to government and private employers. However, as directed in Bush’s veto message, TDI promulgated patient-protection regulations in 1996. The Legislature substantially placed the regulations into law in 1997 by enacting SB 385 by Sibley and SB 383 by Cain. At that time, Texas became the first state to enact comprehensive patient-protection legislation.

The major components of Texas’ patient-protection legislation as originally enacted required HMOs to:

- receive a certificate of authority from the insurance commissioner before operating as HMOs and to submit information covering their network configurations, arrangements for compensating providers, and other data;
- comply with certain practices for contracting with health-care providers, including prohibitions against retaliating against providers who appeal HMO decisions and against using financial incentives that induce physicians to limit necessary services;
- cover out-of-network referrals for medically necessary services;
- provide enrollees with clearly written descriptions of the HMO’s terms and conditions and of enrollees’ options in selecting and changing their primary-care physicians;
- establish standards and processes for quality assurance and complaint management; and
- define emergency care in their benefit policies as health-care services that evaluate and stabilize medical conditions of such onset and severity that a prudent layperson would believe that the condition required immediate medical care.

Supporters of these bills said they would help ensure patients’ access to appropriate care, safeguard physician-

patient relationships, give consumers necessary information to choose HMOs that meet their needs, and give health-care providers due process during plan application and contract termination. They said that health-care costs would not increase because HMOs in Texas had been complying with similar regulations for more than a year.

Opponents said the bills would exceed regulatory requirements and would cause undue government involvement in HMOs’ business decisions and contractual negotiations, which, in turn, would increase health-care costs and hurt consumers. They also said the provisions would do more to improve providers’ bank accounts than to protect patients from harm.

Suit and settlement. In December 1998, Attorney General Dan Morales filed suit against six HMOs in the 250th Judicial District Court in Austin, alleging that the HMOs had used financial incentives that encouraged physicians to limit care, a practice prohibited under the Insurance Code, art. 20A.14(l). For example, Morales alleged that, in regard to certain services, some HMOs had rewarded physicians with bonuses for staying within a predetermined budget and had charged physicians for costs that came in over budget. He also accused the HMOs of giving enrollees deceptive information about plan coverage. The HMOs generally responded that their arrangements with providers were not illegal and reflected standard practices approved by TDI and the federal Health Care Financing Administration, which administers Medicare and Medicaid.

The six HMOs sued by Morales were Aetna U.S. Healthcare, Aetna Health Plans of North Texas, NYLCare Health Care Plans of the Southwest, NYLCare Health Care Plans of the Gulf Coast, Humana Health Plan of Texas, and Pacificare of Texas. Since then, the two Aetna plans have merged, as have the two NYLCare plans.

In April 2000, Aetna settled its portion of the lawsuit by agreeing to halt the practice of rewarding or fining doctors on the basis of a predetermined budget for services. In the settlement, called the Assurance of Voluntary Compliance (AVC), Aetna also agreed to:

- accept a definition of medically necessary care;
- limit arrangements with risk-bearing network providers to those that would support continued enrollee care in the face of extraordinary costs;
- not discriminate against enrollees with acute, chronic, disabling, or life-threatening conditions;

- create an independent ombudsman's office to help consumers;
- cover experimental or investigative therapies under certain circumstances;
- allow enrollees to continue seeing their doctors who drop out of the plan network through the end of the enrollee's plan year;
- assign, only with an enrollee's approval, a doctor other than the enrollee's primary-care physician to direct the enrollee's inpatient care;
- accept limitations on changing prescription coverage during a contract year; and
- waive any preemption defense based on the federal Employee Retirement Income Security Act (ERISA), which exempts some health plans from state regulation.

Aetna agreed to define medically necessary care as "health care services and supplies that under the applicable standard of care are appropriate: a) to improve or preserve health, life, or function; or b) to slow the deterioration of health, life, or function; or c) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury."

Determining whether a service is medically necessary also would involve determining whether the services and supplies are cost-effective. A treatment would be considered cost-effective if it was the least expensive of two or more treatments that were equally effective in achieving a desired

health outcome for that particular patient. Aetna also agreed that the AVC's definition of medically necessary care does not remove the company's duty to comply with any more inclusive definition under a judicial holding, statute, regulation, or determination by any Texas or federal regulating entity with jurisdiction.

While the Morales suit sought fines of \$10,000 per violation from Aetna, the settlement reached by Morales' successor, Attorney General John Cornyn, contains no finding of fault, fines, or penalties. The AVC remains in effect through 2002 unless the attorney general decides before then that the settlement is no longer beneficial to Texas citizens and dissolves the agreement. Aetna serves about 960,000 enrollees in Texas and is the largest health insurer in the United States.

Supporters hailed the settlement as a model for similar suits pending across the country and for the remaining Texas lawsuits against Humana, PacifiCare, and NYLCare. They said the AVC would not drive up health-care costs but would give consumers more power over their health-care choices and doctors more control over medical care. They also said the AVC more clearly specifies patient protections now in law and gives the state clear authority to sue Aetna for violations of the AVC by waiving any protections the firm might claim under ERISA.

Critics of the AVC said the settlement was too easy on Aetna because it simply forced the company to comply with current law without being fined for past practices that had harmed patients or being required to compensate the state for costs of investigation and litigation. They also said the agreement would be successful only if adequately monitored and enforced and might have no long-term benefit for consumers, since it ends December 31, 2002. Some also predicted that Aetna would attempt to compensate for its loss of certain cost controls by raising insurance premiums.

Some critics said the AVC was not a strong enough watchdog instrument. For example, they said, it gave consumers no additional rights to sue HMOs or to enforce the settlement provisions. They noted that all actions against Aetna had to go through the Office of the Attorney General (OAG), which, in the future, might be subject to competing priorities that reduced or limited the office's

responsiveness or enforcement actions.

In July 2000, Rep. Craig Eiland and others questioned whether Attorney General Cornyn had overstepped his authority by giving Aetna a competitive advantage and by including terms in the settlement that could be viewed as changing existing law without an act of the Legislature. Rep. Eiland's concerns included:

- the settlement's definition of medically necessary care, upon which hinge many of the AVC provisions and many other lawsuits against HMOs;
- certain contracting provisions that were debated but not enacted during the 1999 legislative session but are authorized by the AVC;
- whether the AVC committed the Legislature to follow up with legislation that would affect all HMOs; and

Concerns over the terms of the state's settlement of a legal dispute with Aetna may trigger legislative proposals to address state regulation of HMOs.

- whether the AVC, as a model settlement, would force other HMOs to operate and restructure themselves like Aetna.

The House Insurance Committee met on September 18 to address these and other questions. Linda Eads, former deputy attorney general for litigation, told the committee that in her opinion, the settlement did not create new law and does not commit the Legislature to enacting similar provisions governing the remaining HMOs in Texas, because the lawsuit focused specifically on the defendants' violations. She also said that any agreements struck with the remaining HMOs would incorporate provisions that accommodated the HMOs' different methods of operation. She said that a sunset date of 2002 gives the state enough time to monitor Aetna for compliance and for Aetna to incorporate the agreed provisions into its standard business practices, without creating a perpetual oversight role for the OAG. The settlement included no fines, Eads said, because the OAG believed that it had received significant concessions without having to take Aetna to court.

Eads also explained that the AVC's definition of medically necessary care came from definitions promulgated by professional organizations such as the American Medical Association and the American College for Medical Quality. She said that the definition's reference to cost considerations, which critics found inappropriate in a definition that would be used to justify whether a service was medically necessary, recognizes the true nature of HMO decision-making while also limiting the way in which Aetna can use cost in determining medically necessary care. She added that the definition does not supersede state law but clarifies it and creates a basis upon which the attorney general can take action without having to prove that the definition used by Aetna violates state law and intent.

As of mid-December, Aetna was the only defendant to have signed an AVC, although the attorney general was seeking AVC agreements with the other defendants.

Texas legislative proposals. The AVC may trigger legislative proposals by those who remain concerned that the AVC will result in setting standards that are either too lenient or too restrictive for HMO regulation.

Some doctors and others may propose enacting a statutory definition of "medically necessary," because such a determination is involved in many contested

decisions about HMO coverage and treatment and arguably can be viewed as including medical judgment (the practice of medicine) in certain circumstances. Some question whether the AVC's definition can ensure that enrollees get the care they need, and they say that the definition may limit enrollees' recourse in appealing determinations or suing HMOs.

Others counter that a statutory definition of medical necessity would not provide the flexibility that HMO medical directors need to make accurate determinations on a case-by-case basis, and that such a definition could eliminate the cost-control advantages that managed care brings to the health-care system. A statutory definition, they say, ultimately would place in lawyers' hands what is appropriately a doctor's determination.

Lawmakers in the coming session also may revisit legislation concerning "all products" contractual provisions, which require a doctor to participate in all of an HMO's health plans or products if the doctor contracts with one of them. The AVC allows the use of these provisions in contracts with primary-care physician groups of more than 10 doctors. Last session, lawmakers considered but did not enact HB 3179 by G. Lewis, which would have prohibited the use of these provisions. Some say that revisiting the issue will be unnecessary because Aetna used all-products provisions more than any other HMO, and the AVC, by limiting Aetna's use of these provisions, virtually has eliminated the problem.

Other proposals affecting patient protections include bolstering requirements for HMOs to pay providers promptly — for example, by forbidding HMOs to use provisions in their contracts with doctors to avoid or circumvent prompt-payment requirements. Also, HMOs want some assurance when contracting with doctor groups or administrative entities that such groups can bear the financial risk they are accepting. Too many physician groups are going bankrupt, HMOs say, leaving HMOs with the medical costs of enrollees that the groups had agreed to cover.

Federal proposals. The 106th U.S. Congress considered many bills proposing patient protections or a "patient's bill of rights." S. 1344 and H.R. 2990, the major vehicles, passed their respective houses but stalled in conference committee. A version of S. 1344 passed the Senate as an amendment to an appropriation bill, but the conference committee did not adopt it. The major differences in these bills were:

Reviewing HMO Decisions

Health-maintenance organizations (HMOs) and other managed-care plans use a system known as utilization review (UR) to review the medical necessity and appropriateness of health-care services they provide. For example, an HMO conducts a UR when a doctor requests authorization to perform a certain procedure or treatment for a patient covered by the HMO.

A utilization review must comply with the Texas Insurance Code, sec. 21.58A. HMOs conduct UR either by using in-house agents or by contracting with an outside business. UR agents for plans covering Texas residents must be certified by the state and must conduct their reviews under the direction of a licensed U.S. physician. Agents must use written, medically acceptable screening criteria and review procedures that are updated periodically. Screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations on a case-by-case basis.

UR agents must respond within 30 days to complaints filed by patients or health-care providers concerning reviews. Agents also must follow certain notification requirements when making an adverse determination (determining that a proposed treatment or service is not medically necessary). The agent must notify the enrollee and the enrollee's doctor of the

reasons for the adverse determination and must describe the procedure for filing a complaint and appealing the decision, including sending a form that the enrollee may submit to the HMO to appeal the determination to an independent review organization (IRO). An IRO is a nonprofit entity regulated by the Texas Department of Insurance (TDI) that contracts with doctors to review adverse determinations.

An HMO submits the enrollee's IRO-request form to TDI along with copies of correspondence relating to the adverse determination. TDI assigns the case to an IRO and notifies the HMO, enrollee, and doctor of the assignment. The HMO sends the enrollee's medical records to the IRO, which forwards the information to an appropriate doctor for review. Upon completing the review, the doctor notifies the HMO, the enrollee, the enrollee's doctor, and TDI of the determination about the medical necessity of the recommended services. The HMO must comply with the IRO's determination and must pay for the review. An enrollee dissatisfied with the IRO's determination may sue the HMO for failure to exercise ordinary care in making health treatment decisions.

According to TDI, the average length of an IRO review, from TDI's assignment of a complaint to an IRO through the IRO's ruling, is about 16 days.

- S. 1344 primarily would have applied to self-funded ERISA plans, whereas H.R. 2990 would have applied to all health-benefit plans;
- H.R. 2990 would have preempted state laws that prevent the application of the bill's requirements, whereas S. 1344 generally would not;
- H.R. 2990 would have required plans to pay benefit claims promptly;
- S. 1344 would have established a federal board for quality review and research;
- H.R. 2990 would have allowed an enrollee to sue a health-benefit plan for damages under certain circumstances; and
- H.R. 2990 would have allowed associations and community organizations to establish alternative health-benefit plans.

The "right to sue"

In 1997, Texas became the first state to enact a law allowing enrollees to sue their HMOs, although, in most cases, the enrollee first must submit the complaint for review by an independent doctor. Several lawsuits are challenging whether Texas has the authority to enact such a law and the extent to which HMOs must comply with it. Despite these court challenges, enrollees and

Applying and Interpreting ERISA

Congress enacted the federal Employee Retirement Income Security Act (ERISA) in 1974 to regulate employer-sponsored benefit plans, including health plans, and to protect participants and their beneficiaries. ERISA was designed to allow large multistate employers to establish uniform benefit programs without having to meet each state's set of regulatory requirements. ERISA does not apply to the benefit plans of government agencies or religious groups.

ERISA addresses the conduct and responsibility of plan fiduciaries and enforcement mechanisms and supersedes state laws that relate to employee benefit plans. However, because of the complex and sometimes vague structure of ERISA provisions, federal courts have been instrumental in determining which state laws are superseded and to what extent health-maintenance organizations (HMOs) are exempt from state regulation. This evolving definition of ERISA protections is changing the impact and effectiveness of state regulation of HMOs and is forcing enrollees to file negligence lawsuits against HMOs in both state and federal courts to adjudicate their grievances.

ERISA supersedes all state laws that "relate to" employee benefit plans except for laws that regulate

insurance, banking, or securities (29 U.S.C., secs. 1144(b)(2)(A)). However, an employee benefit plan may not be deemed an insurance company or "be engaged in the business of insurance" for purposes of state regulation (sec. 1144 (b)(2)(B)). This second clause effectively prohibits state laws from regulating *self-insured* employer health-benefit plans, in which the employer assumes all risk instead of buying coverage from an HMO or insurance company.

Application of ERISA is complicated by court challenges and interpretations of almost every word in the above provisions. For example, in the 1987 case *Pilot Life Insurance Co. v. Dedeaux* (481 U.S. 41, 47, 107 S.Ct. 1549, 1553), the U.S. Supreme Court interpreted the phrase "relate to" as having a "broad common-sense meaning." Other courts have interpreted this ruling to mean that a state law can relate to an ERISA plan "even if that law was not specifically designed to affect such plans, and even if its effect is only indirect" (*Cigna Healthplan of Louisiana, Inc. v. Louisiana*, 82 F.3d 647 (5th Cir. 1996)). Federal courts have ruled in recent cases that some state laws affecting the administration of HMO plans, such as in determining benefit coverage or in appeals processes, "relate to" ERISA plans and thus are preempted by ERISA. Other court challenges involve

HMOs are using the law's independent-review provisions to settle disagreements over determinations of medical necessity. So far, no one has brought a liability lawsuit to trial.

SB 386 by Sibley made HMOs, health-insurance carriers, and other managed-care entities liable for failure to exercise "ordinary care" when making health treatment decisions. Health plans may be liable for damages if the decisions made by their employees, agents, or representatives harm enrollees.

The law defines "ordinary care" as the degree of care that a managed-care entity or a person of ordinary prudence would use under the same or similar

circumstances. According to OAG staff, a "health care treatment decision" is a decision that affects the quality of the diagnosis, care, or treatment provided to the enrollee. The law defines an "adverse determination" as an HMO's decision that the health-care services furnished or proposed to be furnished to an enrollee are not medically necessary.

To maintain the right to sue an HMO, an enrollee first must exhaust the utilization review (UR) and appeals processes or agree to submit a claim for review by an independent review organization (IRO). (See box, page 5.) An enrollee with a life-threatening illness may appeal an HMO's decision immediately to an IRO, bypassing the UR and appeals processes. An enrollee who already has been harmed by an HMO's decision and who would not

defining “the business of insurance” and determining whether a given state law regulates insurance or employer-sponsored benefit plans.

Malpractice implications. ERISA provides a civil action for beneficiaries seeking to recover due benefits. However, beneficiaries are entitled to receive only the cost of the benefit denied. Under state tort-liability laws, a plaintiff also could sue for compensation for medical expenses, lost wages, injuries, and death resulting from the responsible entity’s actions.

Critics cite a case in which an enrollee sued his HMO because it made a mistake in denying him coverage for a drug to treat his prostate cancer. Because the cancer was so aggressive, the man later underwent surgical castration as recommended by his doctor. When the enrollee returned home from the hospital, he found a letter from his HMO stating that it had made a mistake and that the plan would pay for the previously requested drug. Under ERISA, the enrollee would be entitled only to receive the drug treatment, which now would be a worthless remedy. Under state tort-liability laws, the enrollee could sue for compensation for the surgical castration procedure and its associated suffering and personal loss, as well for punitive damages.

According to critics, HMOs often argue that ERISA preempts tort-liability claims so that they can avoid addressing in court claimants’ arguments that the HMOs have made decisions that harmed enrollees. The question instead becomes whether the state has jurisdiction over the HMO’s action and whether the plaintiff has standing in state court to sue for damages. Thus, negligence claims filed in state courts often must be moved to federal court to determine whether or not the claim is preempted by ERISA and therefore is outside the state court’s jurisdiction.

Critics also say that ERISA’s remedies for wrongdoing were appropriate when health-care insurers provided coverage under traditional fee-for-service plans, but that Congress needs to amend ERISA to reflect modern practices. Under the fee-for-service system, they say, plan beneficiaries got the services they needed and their main concern was payment by the health-benefit plan. Under today’s system of managed care, however, an HMO’s mistake in judgment can mean harm, suffering, loss, or death if an enrollee does not receive needed services. Several federal judges involved in ERISA preemption cases have recommended reexamining ERISA’s civil enforcement and preemption provisions.

benefit from an IRO review does not have to comply with IRO review requirements before filing a lawsuit. An enrollee also may pursue injunctive relief and other remedies if exhausting the appeals and review processes would place the enrollee’s health in serious danger.

In 1999, SB 1884 by Sibley amended the law to *allow* rather than require HMOs to use the IRO process, provided that they follow the procedures defined in law (such as requirements to notify enrollees) and accept the IROs’ determinations as binding. The amendment responded to a federal district court decision, discussed below.

Opponents of the 1997 law said it would cause an avalanche of lawsuits by creating a new cause of action

and would escalate health-care costs. They said it would hold managed-care entities inappropriately to a medical malpractice standard that is relevant only to a doctor’s practice, not to decisions made by business entities. Supporters said the law would ensure that managed-care organizations are held accountable for their health treatment decisions. They also said the law would not create a new cause of action nor escalate health-care costs.

Court challenge. In 1997, SB 386 was challenged in federal district court in Houston. In *Corporate Health Insurance Inc. et al. v. Texas Department of Insurance*, 12 F.Supp.2d 596 (S.D. Tex. 1998), the plaintiffs claimed that ERISA preempts the state’s authority to regulate managed-care disputes. (See box, pages 6-7.)

They argued that the Texas law expressly refers to ERISA plans and that, in mandating the structure and administration of HMO benefits, the law wrongfully binds employers and plan administrators to particular choices, including the adoption of the IRO process as an alternative enforcement remedy.

The state argued that the purpose of the law is to prevent health plans from escaping liability for the medical decisions they make, control, or influence, and that the law does not regulate *how* HMOs make their decisions or structure their benefit plans. The state also said that the plaintiffs characterized all HMO plans offered to employees as ERISA plans, instead of distinguishing between what the state calls an exempt ERISA plan (a self-insured, employer-sponsored health-benefit plan) and one that is established by an insurance business and is *purchased* by an employer to provide coverage for employees.

In September 1998, U.S. District Judge Vanessa Gilmore of Houston ruled that ERISA does not exempt the plaintiffs from Texas law entirely. She agreed with the state that the plaintiffs were operating health plans, not ERISA plans. However, she also found that ERISA exempts from state regulation a health plan's benefit structure and administration and that Texas law inappropriately binds employers and health plans to particular benefit structures. Hence, she ruled that an enrollee may not file suit challenging an HMO's *benefit determination*, the determination of whether the plan covers a benefit or service. Similarly, Judge Gilmore also ruled that HMOs do not have to comply with the law's IRO requirements because the law improperly imposes an alternative process for administering benefits. She severed from the law's requirements all provisions addressing the IRO procedure.

However, Judge Gilmore upheld enrollees' right to sue to challenge the *quality of care* received, saying that such a recourse does not create an alternative enforcement mechanism and is "separate and distinct" from the IRO process for benefit determinations. She noted that a case-by-case determination would need to be made to identify whether an enrollee's claim is grounded on an HMO's benefit determination, which ERISA would preempt, or on medical decisions, which could be challenged in a lawsuit for damages.

Judge Gilmore also ruled that ERISA preempts provisions in SB 386 that prohibited HMOs from using certain clauses in their contracts with health-care providers:

"anti-retaliation" clauses, which allow HMOs to remove from their plans providers who advocate on behalf of their patients, and "hold-harmless" clauses, which indemnify the health plan against its acts or conduct.

The state appealed this ruling to the 5th U.S. Circuit Court of Appeals, which, in June 2000, also found that ERISA preempts the law's IRO provisions because those provisions interfered with a plan's administration and constituted a state-imposed remedy. The ruling in [*Corporate Health Insurance Inc. v. Texas Department of Insurance*](#), 215 F.3d 526 (5th Cir. 2000), written by Judge Patrick E. Higginbotham, echoed Judge Gilmore's decision that the law's liability provisions cover only questions regarding the quality of care that an enrollee receives, and that ERISA preempts challenges to an HMO's denial of coverage.

Contrary to the lower court's decision, the appellate court did not find that the law's prohibitions against anti-retaliation and hold-harmless clauses in HMO contracts interfere with the structure and administration of a health plan's benefits. Rather, the court found these prohibitions consistent with the kind of health-care regulation that has been left to the states through previous case law.

In October, the OAG petitioned the U.S. Supreme Court for a ruling on whether ERISA preempts IROs, but the high court has yet to decide whether to review the case. In the meantime, many hope that the HMOs will continue to use the IRO process voluntarily. They say that this process helps HMOs reduce the number of frivolous lawsuits and projects a good public image to current and potential enrollees.

In the state's favor may be an October 2000 decision by the 7th U.S. Circuit Court of Appeals in [*Moran v. Rush Prudential HMO Inc.*](#), No. 99-2574 (7th Cir. Oct. 19, 2000), which found that ERISA does not preempt an Illinois HMO law requiring independent review, similar to Texas' law. In contrast to the 5th Circuit's ruling, the 7th Circuit found that the Illinois law regulates HMOs, not employee benefit plans. The court also found that the Illinois law cannot be characterized as creating "an alternative remedy" because the court considered existing Illinois law to be incorporated tacitly into the contract under which the plaintiff was insured. The law "simply adds to the contract" a dispute-resolving mechanism "for instances in which the HMO and the patient's primary care physician cannot agree on the medical necessity of a course of treatment," and such requirements should be

treated as mandated terms within a contract, the court said. The ruling reversed a federal district court's ruling that the plaintiff's claims were benefit claims and thus preempted by ERISA.

IRO and lawsuit activity. Since 1997, the Texas insurance commissioner has established and certified three IROs: Texas Medical Foundation, Envoy Medical Systems, and Independent Review, Inc., all in Austin. As of November 1, 2000, the IROs had received 1,079 requests for review of HMO determinations of medical necessity and had completed 1,064 reviews. Of the completed reviews, 42 percent upheld the HMOs' determinations and 50 percent overturned the HMOs' determinations. The rest of the completed reviews partially overturned the HMOs' decisions. For example, an HMO had decided that one week of hospital care was not medically necessary for an enrollee, but the IRO found that four of the seven days of hospitalization recommended were necessary.

No systematic information appears to exist that would indicate whether SB 386 caused health costs to increase because of an increase in "defensive" medical practices, in which doctors prescribe additional tests and procedures to ensure the accuracy of their diagnoses and treatment recommendations.

The first lawsuit against an HMO under the new law was *Ploccia v. NYLCare*, filed in October 1998 in state district court in Fort Worth. The plaintiff alleged that NYLCare had used a "cookbook" approach to psychiatric treatment decisions, which led to the discharge of Ploccia against physician's orders. The day after being discharged, Ploccia drank one-half gallon of antifreeze and died. The case did not involve an IRO review because the defendant died before a review could be conducted, and the law allows cases in which harm already has occurred to bypass the IRO and proceed directly to court.

The state district court removed the case to the federal district court in Fort Worth on the basis of NYLCare's motion that the state had no jurisdiction over the case because of its preemption by the federal Medicare Act's appeals processes. In March 1999, however, the federal court remanded the case to the state court. In July 1999, the case was settled for an undisclosed amount with no responsibility for wrongdoing attributed to NYLCare.

Experts estimate that as many as 25 lawsuits may have been filed under SB 386, but no case has gone to trial.

Texas legislative proposals. Many observers say that SB 386 generally works well. Supporters point to the balanced outcome of IRO decisions as evidence that the process is working fairly for both enrollees and HMOs and can correct many grievances on behalf of enrollees without going to court. They say that these results are being repeated in other states that have adopted an IRO-type system and that the prospect of an IRO review seems to influence HMOs to reconsider some of their decisions. Supporters also say that, contrary to predictions by opponents in the 1997 session, the law has not resulted in a massive filing of lawsuits, nor has it increased health-care costs.

Some say the IRO process could be improved by allowing enrollees to submit documentation to IRO reviewers, instead of requiring the HMO to submit all the information about an enrollee's case. Even if the HMO

complies fully, they say, this presents a conflict of interest, and the HMO may not have access to or know about additional relevant information about the enrollee. Others say that IRO reviewers would become swamped with information that is confusing, inaccurate, or irrelevant to a

good clinical review, thereby delaying IRO decisions.

Some suggest directly linking the anti-retaliation provisions of SB 386 with the prompt-payment provisions of HB 610 by Janek, enacted in 1999 to ensure that HMOs do not threaten doctors who complain about their payment. (See box, page 10.) Others say that such a link is unnecessary because retaliation and delayed payments already are illegal, and the link would not lead to better enforcement of the prompt-payment provisions because it is hard to prove that any action, including delayed payment, is linked directly to a motivation to retaliate.

Some HMOs say that IRO rulings should be required as evidence in any subsequent court proceedings involving an enrollee's claim of harm. They say the IRO review can provide an unbiased starting point in a court's determination of harm, responsibility, and damages. Lawyers challenging HMO decisions counter that IRO rulings should be treated like mediation proceedings, which are confidential and

The 77th Legislature may revisit issues surrounding the state's system for providing independent review of HMOs' determinations of medical necessity.

prohibited by law from being introduced in court. Juries should not be influenced by the opinions of intermediaries who may have biased views of a case, they say.

Federal proposals. Federal court cases that distinguish between medical decisions and benefit-coverage determinations do not offer clear guidelines for determining HMO liability and for the use of IROs and other remedies in Texas. Denying care in some cases could be considered the delivery of poor health care or poor medical judgment, not simply a coverage decision. Such determinations probably would impinge on the definition of medically necessary care, a determination that also can be debated by medical experts. In addition, the contradictory findings of the 7th Circuit and 5th Circuit courts leave the states' use of IROs on uncertain legal ground that the U.S. Supreme Court may need to clear up.

Federal legislative proposals include amending ERISA enforcement provisions to compensate enrollees for injuries or death through the federal enforcement system, and removing the ERISA preemption of state law for cases that involve all types of managed-care liability. Some advocate allowing all managed-care claims to be heard in either a state or federal court but not both, while others advocate splitting the caseload, with state courts hearing claims related to common-law negligence and federal courts hearing claims related to improper benefit determinations and other administrative problems. Opponents say these changes would reduce the federal government's regulatory authority over ERISA plans and would decrease the availability of employee benefits by making them more difficult and expensive to administer and offer.

Several bills in the 106th Congress contained managed-care liability provisions, but the bills stalled in conference committee, largely because of differences between the House and Senate regarding the scope and details of a patient's right to sue.

Joint negotiations by physicians

With the enactment of SB 1468 by Harris in 1999, Texas became one of the first states to allow competing physicians to conduct joint negotiations on managed-care contracts and conditions. The law is set to expire September 1, 2003. Only Washington state had enacted similar legislation, but it excluded fee and discount terms from the allowed negotiations.

Doctor Protections

No retaliation. Texas law prohibits health-maintenance organizations (HMOs) from retaliating against health-care providers and plan enrollees. SB 386 by Sibley, enacted in 1997, forbids a health-insurance carrier, HMO, or managed-care entity to remove or refuse to renew the contract of a health-care provider for advocating on behalf of an enrollee for appropriate and medically necessary treatment (Civil Practice and Remedies Code, sec. 88.002(f)). A federal district judge recently ruled that the federal Employee Retirement Income Security Act (ERISA) preempts the Texas law, but a federal appellate judge reversed that ruling, finding ERISA consistent with state regulatory authority (see page 8).

Art. 20A.14(k) of the Texas Insurance Code, added in 1997 by HB 2846 by Berlanga, prohibits an HMO from engaging in any retaliatory action, including terminating or refusing to renew a contract, against a health-care provider who on behalf of an enrollee has filed a complaint against the HMO or appealed a decision of the HMO. Art. 20A.14(j) of the code, added in 1997 by SB 385 by Sibley, prohibits an HMO from retaliating against an enrollee because the enrollee has filed a complaint against or appealed a decision of the HMO.

Prompt payment. Insurance Code, art. 20A.18B, added in 1997 by HB 610 by Janek, requires an HMO in most cases to respond within 45 days of a health-care provider's submission of a fully completed claim by either paying the total amount, paying the portion of the claim that the HMO does not dispute, or notifying the provider why the HMO will not pay the claim. Penalties for noncompliance include a fine not to exceed \$1,000 for each day the claim remains unpaid.

SB 1468 also allows doctors in certain circumstances to negotiate fee and discount amounts when authorized by the attorney general. The negotiating physician's group may not comprise more than 10 percent of the physicians within the managed-care plan's service area, and

physicians are prohibited from jointly coordinating work slowdowns or strikes.

Physician's groups must submit for the attorney general's approval an initial filing that identifies the physicians, their representative for negotiations, the representative's plan of operations, the health-benefit plan and its service-area population, and the joint negotiation's expected benefits and impact on health care. Any supplemental filings and the contract that results from the negotiation also must receive the attorney general's approval. TDI also must receive a copy of the filings and must assist the OAG in analyzing the impact and approving the physicians' representative.

Opponents said that joint negotiation by physicians would increase medical costs by making it easier for doctors to increase their fees and profits. They said SB 1468 was not needed to allow competing physicians to exchange information for the benefit of patient care, because Texas law already allowed the formation of doctor groups, called individual practice associations (IPAs), that may represent groups of doctors to HMOs. Opponents also said the law would foster anticompetitive health-care contracts, since it did not specifically authorize the OAG to monitor compliance with the negotiated contracts nor to track changes in the marketplace.

Supporters said the law would help prevent dominant health plans from bullying individual doctors into meeting the terms of their contracts, which might not be in the best interests of the doctors or the enrollees. They argued that IPAs are no substitute for the privilege of competing physicians to meet and exchange information solely for the purpose of negotiating with HMOs, mostly because IPAs are expensive to establish, do not cover doctors in solo practice, and do not protect doctors against antitrust lawsuits filed by HMOs. Since the negotiations would be voluntary and nonbinding, they said, HMOs could refuse to participate in negotiations with physician's groups and could turn to other groups or individual doctors.

Negotiating activity. Since SB 1468 took effect on September 1, 1999, the attorney general has received only one filing, from the Federation of Physicians and Dentists of Tallahassee, Fla. The attorney general denied the filing because it did not contain enough information for a sufficient analysis and because the OAG had not yet promulgated rules for the application process. The OAG adopted those rules in May 2000, but the physician's group has not yet refiled.

During last session's debate over SB 1468, TDI estimated that administering the program would cost the state almost \$800,000 to add six full-time employees, to review documents associated with 292 negotiations per year, and to open an estimated 30 additional enforcement cases per year. In developing the rule-adoption order, the OAG estimated that it would handle about 112 filings per year.

Texas legislative proposals. Doctors say that the Legislature should streamline the application process for physician's groups seeking to negotiate with HMOs and should enact measures to protect doctors from the risk of violating antitrust laws when compiling the information required on applications. Physician's representatives and others say that the information required by the OAG is cumbersome, often proprietary, expensive to compile, and sometimes not readily available or collected by doctors in their normal course of business. For example, there is no standard source of market information by which to estimate a contract's impact. They also say that some of the required information requires doctors to share fee schedules and other price lists, thereby placing them at risk of engaging in price-fixing activities prohibited by federal antitrust laws.

The OAG says this documentation is necessary to evaluate the marketplace and protect negotiating doctors from being accused of violating antitrust laws. In defending themselves against such charges, doctors could assert that their negotiating immunity was granted by Texas officials who had considered all necessary factors in balancing the public's benefit with the doctors' benefit.

HMOs say that despite the OAG's analysis, the Federal Trade Commission or the U.S. Department of Justice still can investigate contracts independently. They say HMOs will be careful about entering into joint negotiations because the Texas law does not provide sufficient antitrust protection for physicians, and HMOs do not want to put their physicians at risk.

Doctors also say that the application process is complex and tedious and that doctors fear that their efforts in collecting the necessary information and legally forming a group of doctors for joint negotiations would be wasted if an HMO refused to negotiate. Some doctors want to amend the law to require HMOs to negotiate with doctors who have received the attorney general's approval.

Some doctors also find the fees required by the OAG to be too burdensome and a barrier to engaging in needed joint bargaining with other doctors. The OAG says the fee schedule reflects the costs of labor necessary to meet the office's statutory requirements in reviewing applications. Others say that if the application process were streamlined and made less expensive, the application fees would not present such a barrier.

Federal proposals. At the federal level, doctor's groups have backed legislation that would exempt them from federal antitrust laws. Introduced during the 106th Congress, H.R. 1304, sponsored by U.S. Reps. Tom Campbell (R-Calif.) and John Conyers (D-Mich.), would have exempted health-care professionals, including doctors, pharmacists, dentists, and nurses, from antitrust laws when they negotiate with health plans over contracted health-care services. Professional coalitions for the purpose of negotiating such contracts would have received the same treatment under antitrust laws that labor

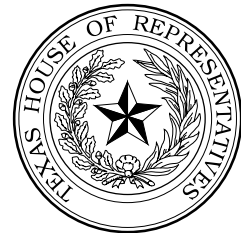
organizations receive from the National Labor Relations Board. The exemptions would have been in effect for three years from the date of enactment. The bill passed the House on June 30 but died in the Senate.

Business groups such as the U.S. Chamber of Commerce opposed H.R. 1304 on the grounds that it would have increased health-benefit costs. Federal antitrust officials and some consumer groups said the bill would have provided an overly broad exemption not warranted by the marketplace and would have improved only physicians' reimbursement, not patient care.

Doctors responded that federal antitrust laws do not take into account the current health-care marketplace in which health-care providers face a virtual necessity to contract with at least one health plan to stay in business. Health-care providers need special antitrust exemptions, they said, because no other professional group is under such constraints when setting up in business.

— by Kristie Zamrazil

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